UC DD
Area Agency on
Aging and Disability

Upper Cumberland Development District
District Public Guardianship for the Elderly Program | Intake Form
1104 England Drive; Cookeville, TN 38501 | Phone: 931-476-4139 | Fax: 931-476-4099
Please email completed intake packet to: pginfo@ucdd.org

DATE: _____

PERSONAL INFORMATION		
Client's referral date:		
Client's full name:	**Client's date of birth:**	**Client's Social Security Number:**
Client occupation:	**Client's employer:**	**Client's address and telephone:**
Mother's maiden name:	**Mother's place of birth:**	**Mother's date of birth:**
Father's name:	**Father's place of birth:**	**Father's date of birth:**
Client's city, county, state, and country of birth:		
Current residential address:		
Current mailing address:		
Residential county:	**Type of residence:**	
Directions to Residence:		
Sex:	**First language:**	**Race/Ethnicity:**
Highest educational level obtained:	**Profession:**	

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Religious affiliation:	**Clergy's name:**	**Clergy's phone number:**
Veteran: Choose One	**Branch:**	**Dates of service:**
SUPPORT SYSTEM		
Marital Status:	**Number of Marriages:**	**Date of marriage(s):**
Spouse's residential address:	**Type of residence:**	
Spouse's Name (even if deceased):	**Spouse's date of death (if deceased):**	
Spouse's Social Security Number:		
If deceased, spouse's burial location:	**If spouse deceased, funeral home:**	
Was spouse a veteran? Choose One	**Branch:**	**Dates of service:**
Veteran's Administration Number:		
Child:	**Address:**	**Phone number:**
Child:	**Address:**	**Phone number:**
Child:	**Address:**	**Phone number:**
Family member: **Relationship:**	**Address:**	**Phone number:**
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Family member: **Relationship:**	**Address:**	**Phone number:**
Neighbor/Friend:	**Address:**	**Phone number:**
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Background information: **Family/Friends:**		
Home service provider:	**Address:**	**Phone number:**
Description of home services being provided:		
Other home/community-based services being received:		
Medical equipment supplier:	**Address:**	**Phone number:**
List of medical equipment:		

HEALTH INFORMATION		
Primary Care Physician:	**Address:**	**Phone number:**
Other Physician/Specialist:	**Address:**	**Phone number:**
Other Physician/Specialist:	**Address:**	**Phone number:**
Hospital of choice:	**Address:**	**Phone number:**

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Pharmacy of choice:	**Address:**	**Phone number:**
Medicaid number:	**Medicaid effective date:**	
TennCare Choices MCO:	**TennCare Choices Care Coordinator:**	
Medicare Pt. A Number:	**Medicare Pt. A effective date:**	
Medicare Pt. B Number:	**Medicare Pt. B effective date:**	
Medicare Pt. D Provider name, address, and phone number:	**Medicare Pt. D Number:**	
Medicare Advantage Plan:	**Address:**	**Phone number:**
Medicare Supplement Plan name, address, and phone number:	**Address:**	**Phone number:**
TennCare Choices MCO:	**TennCare Choices Care Coordinator:**	
Current medical condition:		
Medical history: *(Please attach the most current history and physical examination and physician's orders list if available.)*		
Current medications name, amount, dosage:		

Mental status includingall known diagnoses:			
Communication:	**Cognitive status:**		**Ambulation:**
FINANCIAL INFORMATION			
Amount of Social Security:	**Amount of SSI:**		**Amount of SSDI:**
Amount of VA Benefit:	**Type of VA Benefit:**		**Draws on self or spouse:**
Amount of Railroad Retirement:	**Other income:**		**Other income:**
Amount in additional bank account:	**Type of account:**	**Bank name:**	**Bank address:**
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Safety Deposit Box: Choose One	**Location of Safety Deposit Box:**	**Address:**	**Name of person with key:**

Real estate address:	**Type of real estate:**	**Is the client the sole owner?**	**If not, who is/are the other owner(s)?**

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Personal property (including any vehicles, jewelry, etc.):			

Life Insurance Company:	**Address and phone number:**	**Policy number:**	
Amount of Life Insurance:	**Is policy paid up?**	**Cash value of policy:**	**Beneficiary:**
Life Insurance Company:	**Address and phone number:**	**Policy number:**	
Irrevocable Trust:	**Address and phone number:**	**Policy number:**	

Monthly expenses amount:	**To whom:**	**Monthly expenses amount:**	**To whom:**

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END OF LIFE WISHES

POST Form?	**Location of POST:**	**Advance Directive?**	**Location of Advance Directive:**
Does the client wish to have a funeral and be buried? Choose One	**Funeral home:**	**Funeral Home Address and phone number:**	
Cemetery of choice:		**Address and phone number:**	
Does the client wish to be cremated? Choose One		**Crematory:**	**Crematory address and phone number:**
Funeral/cremation paid for?		**Actions to take with ashes/gravesite:**	
Does the client have a will? Choose One		**Location of Will:**	
Attorney who drafted Will:		**Individual to contact in event of death:**	

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LEGAL INFORMATION	
Does client have an attorney?	**Contact information for attorney:**
Does the client have a Durable Power of Attorney? Choose One	**Contact information for attorney who drafted DPOA:**
Attorney-in-fact name:	**Contact information:**
Location of DPOA:	**Comments:**
Is the client currently under conservatorship by another person or entity? Choose One	**If yes, whom? Provide address and phone number:**

TYPE OF SERVICE REQUESTED	
Conservator of person and property: ☐ Yes ☐ No	**Durable Power of Attorney for healthcare and finances:** ☐ Yes ☐ No
Conservator of person: ☐ Yes ☐ No	**Durable Power of Attorney for healthcare:** ☐ Yes ☐ No
Conservator of property: ☐ Yes ☐ No	**Durable Power of Attorney for finances:** ☐ Yes ☐ No

REQUESTED BY	
Name of person completing application:	**Address and phone number:**
If there is a petitioning attorney in this case, please list name:	**Address and phone number:**
APS Counselor:	**APS Counselor contact information:**